THE 'GOOD' REFUGEE IS TRAUMATIZED: POST-TRAUMATIC STRESS DISORDER AS A MEASURE OF CREDIBILITY IN THE CANADAIAN REFUGEE DETERMINATION SYSTEM

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The 'Good' Refugee is Traumatized:
Post-traumatic stress disorder as a measure of credibility in the Canadian Refugee Determination System

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Abstract

Through a social construction theoretical framework, it is explored how the Immigration and Refugee Board utilizes a diagnosis of PTSD as a measure of credibility during the refugee determination process, and how this is deemed problematic due to the barriers that exist for the refugee population in the mental health system. This research project was framed around two primary research questions: (1) how does a mental health diagnosis of PTSD impact the refugee determination process in Canada? And, (2) is a diagnosis of PTSD for a refugee claimant accurate and appropriate? Semi-structured elite interviews were conducted with health care professionals who interact with the refugee population in Toronto. The findings indicate that there is an identifiable paradox between PTSD being utilized as a measure of credibility and PTSD being a social construction that is rendered inappropriate for individuals who originate in a non-Western culture. This research project demonstrates the existence of the paradox by analyzing the multi-faceted barriers that refugee claimants face in proving that their stories are credible, and the barriers in the accessibility and delivery of mental health care in Canada.

Key words: Refugees; Refugee determination system; Post-traumatic stress disorder

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In dedication to Steve, Noreen, Keirsten and Ryan,
And their hearts of gold.

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> *"The asylum process, like any form of mass adjudication of individual cases, tends to flatten out difference, demand simplicity over nuance, and compel the distillation of messy, complicated lives down to a manageable set of narrative fragments that can be inserted into the legal pigeonholes of the refugee definition" (Macklin, 2009, p.137).*

1. Introduction

1.1 Research Background

At the end of 2013, the United Nation's High Commissioner for Refugees (UNCHR) annual Global Trends report showed that over fifty-one million people were forcibly displaced – which is six million more than the reported amount at the end of 2012 (UNHCR, 2013).

> *"We are seeing here the immense costs of not ending wars, of failing to resolve or prevent conflict, […] political solutions are vitally needed. Without this, the alarming level of conflict and the mass suffering that is reflected in theses figures will continue" (UNHCR, 2013).*

Among the forcibly displaced there are over one million people seeking asylum and claiming refugee status. Although the developing world is host to over four-fifths of the world's refugees, the majority of applications for asylum are submitted in developed countries, including Canada (UNHCR, 2013). Canada has a long history of providing a safe harbor to refugees as a part of fulfilling its humanitarian obligation to the international community. However, a country once praised for its bleeding heart is currently facing scrutiny: "All Canadians must now understand that our humanitarian tradition and our openness towards refugees are historic artifacts" (Dauvergne, 2013, para.11). It is argued, "it is easy to dismiss the

current debate about changes to Canada's refugee process as the same-old stand-off between the soft liberal left and a strong reformist government. But the tenor of the recent changes has irrevocably altered the terrain" (Dauvergne, 2013, para.2).

At the end of 2012, the Conservative government made drastic changes to the Canadian refugee determination system, in accordance with Bill C-31 – Protecting Canada's Immigration System Act. The reform introduced new anti-smuggling provisions, designated countries of origin, and unfair timelines for refugee claims (Canadian Council for Refugees, 2012). The logistics of the system will be discussed in greater detail in sub-section 1.3.2.

It is argued that the changes are based upon a 'bogus' discourse regarding refugee claimants that has been disseminated by the Conservative government. The discourse creates a binary between the 'good' refugee and the 'bad' refugee. It appears that the discourse of the nation-state has had a significant impact on asylum seekers. It is reported that "in total, Canada received half as many asylum claims in the first half of [2013] as it did during the same period of [2012] – 4,558 compared to 10,375" (Cohen, 2013). And, once claims are made, it is reported that there has been "a general decline in refugee acceptance rates which may be correlated with shifts in the focus of refugee policy" (Gojer & Ellis, 2014, p.4). As an extension of this, it is noted that the changes to the refugee determination process has resulted in increased demands on refugees to prove credibility, or rather, to prove that they are a 'good' refugee (Gojer & Ellis, 2014). Thus, in this way it becomes the refugee claimant's responsibility to prove that their story is one that makes them worthy of protection. And, this is particularly difficult when the humanitarian mandate of the state is being replaced by a discourse that portrays the asylum seeker as "fraudulent".

Although the refugee determination process is multi-faceted, it is reported "lawyers and asylum seekers are drawing on post-traumatic stress disorder as a vehicle toward credibility and access to Canada" (Gojer & Ellis, 2014, p.6). The appropriateness of using post-traumatic stress disorder as a measure of credibility for a refugee claim has materialized as a new issue in refugee research. The importance of this research project can be identified as expanding on the new literature, particularly a recent research paper published by the Policy Development and Evaluation Service of the UNHCR, concerning the relationship between post-traumatic stress disorder and the refugee determination system. This study adds to the existing literature by drawing on qualitative data collected through semi-structured elite interviews with health care professionals who interact closely with the refugee population in Toronto. This research project provides a unique perspective from the service provider on barriers for refugees in accessing mental health services.

1.2 Research Questions

This research project is framed around two primary research questions: (1) how does a mental health diagnosis of post-traumatic stress disorder impact the refugee determination process in Canada? And, (2) is a diagnosis of post-traumatic stress disorder for a refugee claimant accurate and appropriate?

To address these questions, I seek to explore the emerging phenomenon of a mental health diagnosis of post-traumatic stress disorder being used as a symbol of credibility in the refugee determination process. And, I seek to identify the barriers that exist for the refugee population in the mental health system and how this impacts the validity of a diagnosis for someone who originates from a non-Western culture.

1.3 Terms and Definitions

For the purposes of this paper, it is important to have a comprehensive understanding of three entities: the refugee claimant, the refugee determination system and post-traumatic stress disorder.

1.3.1 The Refugee Claimant

It is important to note that there will be a focus on a refugee claimant rather than a Convention refugee. A Convention refugee is a person who meets the refugee definition in the 1951 Geneva Convention relating to the Status of Refugees. To meet the definition, "a person must be outside their country of origin and have a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion" (Canadian Council for Refugees, n.d). They are government-assisted or privately sponsored refugees. A refugee claimant, often referred to internationally as an asylum seeker, is "a person who has made a claim for protection as a refugee […] and until a determination is made, it is impossible to say whether the asylum seeker is a refugee or not" (Canadian Council for Refugees, n.d). This distinction follows the notion that the Convention refugee is a 'good' refugee, and an asylum seeker is a 'bad' refugee.

1.3.2 The Refugee Determination System

The Canadian refugee determination system underwent changes in December 2012 as a result of the coming into force of the Balanced Refugee Reform Act and the Protecting Canada's Immigration System Act. For the purposes of this paper there will be a focus on refugee claims made at a 'port of entry' rather than 'inland claims'. Upon arrival, a Canadian Border Services

Agency officer will determine whether a claimant fulfills the eligibility criteria. If the claim is found eligible, the person will receive a refugee claimant identity document, a date for a refugee hearing at the Immigration and Refugee Board, a Basis of Claim form, and a conditional removal order. The refugee hearing will take place within forty-five days and sixty days, for claimants from a Designated Country of Origin, and for other claimants, respectively. It is the responsibility of the Refugee Protection Division of the Immigration and Refugee Board to decide the outcome of the refugee claim (Macklin, 2009). Although the refugee determination process is a multi-faceted and complex process, this paper will focus on the Basis of Claim document, and the attached documentary evidence. More specifically, there will be a focus on the psychiatric report as an attached document.

1.3.3 Post-traumatic Stress Disorder

There will be a primary focus on post-traumatic stress disorder, as the dominant mental health diagnosis that is found on the psychiatric report for the refugee determination process.

Post-traumatic stress disorder was first recognized as a mental disorder in the third version of the Diagnostic Statistical Manual (DSM) in 1980. The fifth version of the DSM, released May 2013, identifies post-traumatic stress disorder as a Trauma-and Stressor-Related Disorder, as opposed to an Anxiety Disorder, as it was originally classified (American Psychiatric Association, 2013). In order for an individual to be warranted a diagnosis of post-traumatic stress disorder, they must meet the criteria listed in the DSM, which has been altered since version three. Currently, the individual must have been subjected to a trigger and must manifest a response, both of which are defined in accordance with specific characteristics. The trigger must entail exposure to actual or threatened death, serious injury or sexual violation

(American Psychiatric Association, 2013). The individual must directly experience, witness, learn about, or be subjected to repeated exposure to the traumatic event (American Psychiatric Association, 2013). In addition, the traumatic event must cause a response that impairs normal functioning and lasts the duration of more than one moth, and encompasses the experience of intrusion, avoidance, alterations in mood, and alterations in arousal (American Psychiatric Association, 2013). It is reported that the frequency of post-traumatic stress disorder among the refugee population ranges from thirty nine to one hundred percent, compared to one percent of the general population (Gojer & Ellis, 2014).

2. Theoretical Framework and Scholarly Context

In seeking to understand the impact of a mental health diagnosis of post-traumatic stress disorder on the refugee determination process, this chapter explores the over-arching, multi-faceted theoretical framework and the existing scholarly literature.

2.1 Social Construction

At the top of the theoretical framework hierarchy is social construction. For the purposes of this paper, the refugee claimant, mental illness, and post-traumatic stress disorder will be analyzed through a social construction theoretical lens.

Social construction is often described alongside relativism, and is compared to realism. A primary assumption of realism is that reality is self-evident and stable, and that knowledge is purely rational. This assumption is based on the premise that there is "a real world out there and that scientific methods and reliance on systematic observation and experimentation [are] capable of giving us objective knowledge about that world" (Fletcher, 1996, p.409). However, social constructionists argue that reality is not something that is naturally given; rather, "the world is largely created by the human mind" and knowledge is "derived from the societal context" (Fletcher, 1996, p.410). Thus, reality is an invention that is constantly negotiated and modified. The following sub-sections will describe how the refugee claimant, mental illness and post-traumatic stress disorder are social constructions, rather than entities that are objective truths.

2.2 Social Construction: the Refugee Claimant

The social construction of the refugee claimant is best described using the concept of refugeeness. For the purposes of this research project, there is a focus on the trajectory of the refugee subjectivity from their country of origin to the country of asylum. The fleeing individual's past subjectivity is subordinated to a new subjectivity – that of a refugee claimant (Lacroix, 2004). Although an individual has a multi-faceted subjectivity, it can be argued that the refugee's most prominent subjectivity upon claiming asylum is that of refugeeness. An individual is stripped of their past subjectivity and becomes a refugee claimant, who is required to prove their refugeeness when they are confronted with a refugee determination process (Lacroix, 2004).

The Canadian refugee determination system is built upon the premise that asylum seekers must prove that they meet the standard of proof for refugee status. The criterion for refugee status is outlined in the 1951 Refugee Convention and the 1967 Protocol Relating to the Status of Refugees (Gojer & Ellis, 2014). However, there ceases to a national or international convention that stipulates credibility as a necessary requirement. Nonetheless, as cited in Gojer & Ellis, 2012, "credibility is always an issue…the majority of claims are determined on the basis of a subjective analysis, [of] whether or not the panel believes the claimants story" (Pieters, 2004, p.1). The notion of credibility is often measured during "the trauma transmission process during the hearing, which entails both a reenactment by the claimant of the harm influenced upon him/her, and the capacity of the adjudicator to share and understand the Other's experience" (Rousseau & Foxen, 2010, p.71). This is described as a difficult process because there are so many "barriers standing between [the adjudicator] and 'what really happened'" (Macklin, 1998, p.137). The ability to determine credibility is often hindered

because “assorted governmental and human rights reports that the [Immigration and Refugee Board] receive usually paint a canvas with broad, crude brush strokes. They rarely provide the kind of detailed information that would be necessary to corroborate a particular story” (Macklin, 1998, p.137).

In Canada, it is reported that there has been a general decline in refugee acceptance rates, which may be correlated with shifts in the culture towards refugee claimants. The ‘bogus’ discourse that has emerged regarding asylum seekers is linked to the notion of credibility, whereby the refugee claimant must demonstrate that they are genuine.

Although “to seek asylum is a universal right possessed by all individuals, the right to grant asylum is maintained by sovereign states and their apparatus of inclusion/exclusion” (Nyers, 2002, p.53). The sovereignty of the nation-state is at the forefront of discussions regarding the movement of migrants. Consequently, the culture of the Immigration and Refugee Board radiates around the notion that as decision makers, and as gatekeepers, they are tasked with “protecting Canada’s borders from unscrupulous and underserving migrants who abuse the asylum system to gain entry” (Macklin, 2009, p.158). Because this environment is characterized by a “pervasive suspicion regarding asylum seekers” and a “presumptive skepticism” it is of utmost importance that the decision maker is satisfied that the refugee claimant meets the criteria of what it means to be a refugee (Macklin, 2009, p.159). And, it is the concept of refugeeness that becomes interlinked with credibility.

To determine credibility the Immigration and Refugee Board asks ‘What happened to you?’ which is inherently linked to the question: ‘Who is a refugee?’ Alongside these questions is the dichotomy of the ‘good’ refugee and the ‘bad’ refugee. In order to be a ‘good’ refugee,

the refugee claimant subjectivity is transformed into refugeeness. Refugeeness is an expectation of how a refugee should look and act and implies certain social and moral conduct rendered to be appropriate for a refugee (Narula, 2013). From the moment that an individual becomes a refugee claimant, they begin the process of repeating their story – "on each occasion translated, summarized, reworked, massaged and interpreted by the recipient, and all the time adding to an every growing bureaucratic record of their experiences before and during flight" (Zajor, 2011, p.22). As cited in Zajor, 2011, their story must fit the image of the 'good' refugee – likened to "hordes of nameless, despairing, and dispirited masses […] desolate and pitiful" (Matua, 2011, p.9). "The refugee who displays too much autonomy is portrayed as duplicitous, a queue jumper, opportunist and liar, weaving tall tales to trick the authorities and therefore lacks the requisite genuineness" (Zajor, 2011, p.12). Thus, it becomes a logical argument that the refugee claimants who are 'recognized' as 'good' refugees "may be those most adept at positioning themselves within the dominant discourse of powerlessness, needing to be saved by the 'good' state" (Zajor, 2011, p.9). Refugeeness, as a social construction, is a byproduct of Canada's immigration and refugee policy, and more specifically, the refugee determination process.

Because a 'good' refugee is helpless, weak, and vulnerable – the refugee claimant subjectivity must become defined by these characteristics. An emerging body of scholarly literature has established links between the notion of credibility and a mental health diagnosis of post-traumatic stress disorder. Post-traumatic stress disorder becomes the label that symbolizes the suffering of the 'good' refugee. It is claimed that the Immigration and Refugee Board is "inadvertently using the language and ideology of post-traumatic stress disorder as a

measuring stick to determine the credibility of asylum seekers" (Gojer & Ellis, 2014, p.2). This means that decision makers are increasingly drawing on "medical evidence to discern between the credible-good refugee and the malingering-bad refugee" (Gojer & Ellis, 2014, p.17). In short, post-traumatic stress equals credibility.

2.3 Social Construction: Mental Illness

However, an emerging body of scholarly literature has identified the problems that are associated with diagnosing an individual who originated in a non-Western culture with a mental disorder diagnosis. This argument is based on the notion that mental illness is a social construction, whereby mental illness is "inseparable from the cultural models that define them as such" and "the defining characteristics of mental illness reside in the cultural rules that define what is normal or abnormal" (Horwitz, 2002, p.6).

A realist approach is inherently linked to the biomedical model of mental illness that assumes that the manifestation of a mental illness is consistent across every population due to the universal physiology of mankind (Thakker, Ward & Strongman, 1999). The DSM, the psychiatric screening tool used in Western culture, is based upon the biomedical model. The DSM is a classification system based on a set of symptom-based criteria that are claimed to be objective (Kirk, Gomory & Cohen, 2013). Mental illnesses, according to the DSM, are universal, cross-culturally valid and invariant to time or place (Kienzler, 2008).

The social construction of mental illness is not a new phenomenon: a number of scholars have refuted a realist approach in favour of the social constructivist perspective. The origins of this framework began with Emile Durkheim who transformed the object of sociological analysis from individual behaviours to the cultural systems that define the meaning

of the behaviours (Horwitz, 2002, p.7). Ruth Benedict asserted, “Normality thus resides in culturally approved conventions, not in universal psychological standards of appropriate functioning” because the behaviours that are defined by the Western psychiatric model as abnormal can be considered normal in other cultures (Horwitz, 2002, p.7). Michael Foucault viewed “madness as a property of cultural categories rather than of individual symptoms” (Horwitz, 2002, p.8). Thomas Scheff extended the social constructivist perspective into American sociology by introducing the notion that psychiatric symptoms are norm-violating behaviours specific to a culture rather than intrapsychic disturbances within individuals (Horwitz, 2002, p.8). Thomas Szasz, a primary opponent of the realist approach draws on an analogy between mental illness and witchcraft. In short, “witchcraft and mental illness are imprecise and all-encompassing concepts, freely adaptable to whatever uses the priest or physician wishes to put them” (Szasz, 1970, p.1). Alongside these arguments, in summary, social constructionists question the factual status of mental illness and instead, claim that in accordance with the Western psychiatric model mental illnesses are not discovered, rather they are invented (Szasz, 1974).

2.4 Social Construction: Post-Traumatic Stress Disorder

In accordance with the social construction of mental illness, it appears that this framework can be extended to the diagnosis of post-traumatic stress disorder. There is an ongoing debate within scholarly literature regarding the conceptualization of the refugee experience, especially with the emerging trend of transforming the experience of trauma into post-traumatic stress disorder.

The realist approach endorses post-traumatic stress disorder as a cross-culturally valid psychopathological response to traumatic distress, which can be ameliorated with Western clinical techniques (Kienzler, 2008). Because the DSM supplies a checklist of the criteria attributed to a post-traumatic stress disorder diagnosis, the realist presumes that every individual will elicit the identical physiological reaction to stress. Thereby, Western realist psychiatrists have a worldview that privileges biology over culture (Eisenbruch, 1991). And, at the heart of this perception is that it is normal to be traumatized if one is a 'good' refugee, and this traumatization merits a post-traumatic stress disorder diagnosis (Kienzler, 2008).

However, the social construction framework poses this as erroneous; a noteworthy amount of literature suggests that mental illnesses are not spread evenly across the globe. Post-traumatic stress disorder is described as a 'transient mental illness', or rather, a disorder that is located in a particular set of cultural understandings (Hacking, 1998). The conceptualization of trauma is based on cultural perceptions of the manifestation of 'normality' (Kienzler, 2008). The notion of 'normality' embodies certain questions: what is a reasonable risk; what is acceptable behaviour at a time of crisis; and, how should distressed be expressed (Summerfield, 2001). It can be argued that due to the criteria posited by the DSM for a post-traumatic stress disorder diagnosis, the answers to these questions could be answered as if all individuals exposed to a traumatic event are a homogenous group. The social construction framework would argue that this assumption is false. The literature identifies the notion of cultural bereavement as a beneficial alternative to understanding the trauma experienced by a refugee claimant (Eisenbruch, 1991). Cultural bereavement denotes the experience of trauma

not as a disease, but as an understandable response to a catastrophic event, and that the response is manifested according to the norms of one's culture (Eisenbruch, 1991).

It is argued that the refugee experience, which often coincides with a traumatic event, has become "subsumed by a medical etiology of trauma that is static, de-racialized, and value neutral" (Chu, 2008). The Western "psychiatric sciences have sought to convert human misery and pain into technical problems that can be understood in standardized ways" (Summerfield, 2001, p.4). Because of this, it is cautioned "human pain is a slippery thing" and "how it is registered and measured depends on philosophical and socio-moral considerations that evolve over time and cannot simply be reduced to […] compartmentalized diagnostic categories which have become legitimized through the language of mental health and the DSM" (Gojer & Ellis, 2014, p.7).

The social construction framework claims that the medicalized trauma discourse embedded within the Western psychiatric model is based upon erroneous assumptions. Some scholars go as far to argue "post-traumatic stress disorder is a narrowly defined social constructed psychiatric category that fails to capture a holistic view of people's trauma and should not be utilized as a tool to measure the credibility of refugee trauma" (Gojer & Ellis, 2014, p.6). Correspondingly, it is cautioned that it would be unfortunate if post-traumatic stress disorder was recognized as a signifier of past suffering, because there is the risk that the stories of victims who could not obtain a diagnosis would not be believed (Summerfield, 2001).

2.5 The Settlement System in Canada

In addition to the social construction theoretical framework, it is important to provide information on the current state of the immigration and refugee settlement system in Canada.

There are barriers for newcomers in receiving settlement services; and, upon further exploration it is evident that this is a systemic issue that has radiated down to frontline services.

According to Citizenship and Immigration Canada, the operation of the settlement system is the responsibility of the federal government, the provincial government and the non-for-profit sector (Sadiq, 2004). However, it is argued that because "neither the federal government nor the provincial government provides services to newcomers" (Sadiq, 2004, p.23), the municipalities undertake the bulk of settlement work (McGrath & McGrath, 2013). However, this is problematic; as cited in the literature Canada's settlement system follows the notion of the shadow state whereby settlement services are funded through contractual agreements between the nation-state and the non-for-profit sector (Sadiq, 2004). Thus, "the supply of newcomer services is directly affected by settlement funding" from the federal government (Sadiq, 2004, p.13).

Regrettably, the number and breadth of newcomer services has been influenced by federal funding cutbacks (Sadiq, 2004). In 2010 the federal government announced that 583 million dollars would be allocated to settlement services in Canada for 2011-2012, compared to 622 million dollars in the prior year; and for 2012-2013 the total would decline to 577 million dollars (Elliott & Payton, 2011). And, the majority of the funding has been cut from Ontario's settlement system, compared to the other provinces (Keung, 2010). In doing so, the smaller immigrant settlement agencies are the most affected; thus eliminating the culturally and linguistically sensitive services that are critical to the integration process (Sadiq, 2004). The research is consistent that receiving settlement services, including assistance with language, employment, housing, and education, is a significant factor in the success of newcomers. And, it

is the local municipalities and the not-for-profit sector that allows for the flexibility and innovation of these services in order to meet the unique needs of the newcomer population (McGrath & McGrath, 2013).

3. Methodology

In seeking to provide answers to the research questions described in section 1.2, this research project utilized a qualitative research design that involves semi-structured elite interviews with health care professionals who interact with the refugee population in Toronto. The data analysis is rooted in grounded theory, whereby distinct themes emerge and linkages are established.

3.1 Research Instrument

The research design for the purposes of this project, as mentioned previously, is based upon semi-structured elite interviews with health care professionals in Toronto. The participants will be discussed in greater detail in section 3.2. Elite interviews are valuable for the collection of specialized information: the ability to extract detailed and otherwise inaccessible information is heightened. A semi-structured interview design encompasses a previously constructed framework of questions that draws upon themes of interest. A pre-set framework is intended to ensure that the core questions are asked in each interview, but still allows for flexibility in the participants answers to be retained (Archer & Berdahl, 2011). The framework consists of open-ended questions that allow for the emergence of new ideas, and the ability to ask for clarification, elaboration, and additional information that may be of use.

Because this research design involves the interaction with human beings, it had to be approved under the merits of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Human beings (TCPS)* by the Research Ethics Board at Ryerson University. This study was conducted parallel to ethical principles. Because the participants, by definition, were not

considered a vulnerable population, the two primary ethical considerations were to ensure free, informed and ongoing consent, and confidentiality.

3.2 Participants and Recruitment

At the forefront of the research design is the human subject; it is of great importance to choose the potential participants based on their ability to supply specialized information that can be used to address the research questions (Archer & Berdahl, 2011). For the purposes of this research project it was initially determined that primary care physicians that work directly with the refugee population would be the most appropriate participants, but in order to incorporate additional perspectives across the mental health care spectrum, this category was subsequently expanded to include nurse practitioners and psychiatrists. All of the participants work in the downtown core of Toronto. The participant screening process entailed two main criteria: direct interaction with refugees for the purposes of mental health and specialized knowledge regarding mental health diagnosis. The decision to interview health care professionals rather than refugee claimants, settlement workers, lawyers, or members of the Immigration and Refugee Board was based upon the desire to collect information from the individuals who are responsible for applying the mental health diagnosis upon the refugee claimant. The health care professionals who interact with the refugee population have unique insight into the barriers that are associated with applying a mental health diagnosis. This research project also offers a unique perspective of the service provider, rather than of the service user.

The participants were recruited through a purposive sampling strategy. Because of the time restraints, purposive sampling ensured that subjects who were sought to participate

would provide the greatest amount of information (Archer & Berdahl, 2011). To begin this process, the key informant technique was utilized, whereby an individual deeply immersed within the refugee mental health environment as a member of the Board of Directors for the Canadian Centre for Victims of Torture and the Manager of the Health Equity Department at the Centre for Addiction and Mental Health provided guidance to the most appropriate subjects. The subjects contact information was accessed through public websites of the respective hospitals or community clinics, such as the Cross Road's Clinic, St. Michael's Hospital, and Mount Sinai Hospital, or through contacting the respective organizations that they were employed by, such as Access Alliance, the Canadian Centre for Victims of Torture, and the Centre for Addiction and Mental Health. The potential subjects were delivered an email script that requested their participation in the study and clarified the purpose of the interview. Upon their response and their approval to participate in the research project, the date, time and location were decided based upon availability. The research design sought to recruit eight to ten participants, and all of the fourteen potential participants who were contacted responded, but due to time restraints nine health care professionals were successfully recruited and interviewed in this research project. This included five primary care physicians, three psychiatrists, and one nurse practitioner.

3.3 Data Collection

The semi-structured elite interviews were conducted during a four-week time span. The length of the interviews ranged between nine minutes and twenty-five minutes, with an average of eighteen minutes. In order to standardize the research instrument, the interviews were conducted face to face at the participant's place of work. Furthermore, three interviews

were conducted on the telephone to provide an additional perspective. The interview consisted of a pre-set framework that contained ten open-ended questions. The questions incorporated the following themes: the characteristics of the refugee population in Toronto; the language and cultural barriers; the positive and negative aspects of using the DSM with the refugee population in North America; the accuracy of a mental health diagnosis of post-traumatic stress disorder; the treatment approaches utilized with the refugee population; the measures that should be implemented for the improvement of the accessibility and delivery of service provision and health care; and the interaction between the mental health system and the refugee determination system. As consented by the participants, each interview was audio-recorded. Following the completion of an interview, the content was transcribed verbatim for the purpose of data analysis.

3.4 Data Analysis

The data analysis for the research project is based upon the face-to-face interviews and is rooted in grounded theory. It begins with meticulously reading through the transcriptions and with the process of coding. The process entails the completion of three sequential phases: open coding, axial coding and selective coding (Birks & Mills, 2011). First, in open coding, a thorough analysis is conducted of the collected data. This results in the segmentation of information to form categories based upon noticeable patters (Birks & Mills, 2011). Initially, the categories that emerged during open coding were almost parallel to the themes that were incorporated in the questions being asked: refugee characteristics, language barriers, cultural barriers, the appropriateness of the DSM and the cross-cultural accuracy of post-traumatic stress disorder, and the treatment approaches.

Second, in axial coding, the data is assembled in novel ways following the open coding process. This exercise results in the development of conceptual patterns in the analysis (Birks & Mills, 2011). As the interviews and data analysis proceeded, the axial coding began – the participants, with the usage of probes, continuously made references to the relationship between the notion of credibility, the refugee determination process, and a diagnosis of post-traumatic stress disorder. As a result, the refugee determination system was established as a separate category, in addition to: characteristics of the refugee population, systemic barriers, language barriers, cultural barriers, positive and negative aspects of the DSM, the appropriateness of post-traumatic stress disorder, and treatment approaches.

Lastly, in selective coding, the saturation of categories is sought, whereby upon further analysis the creation of additional categories is not necessary (Birks & Mills, 2011). Either a 'story line' emerges that details connections between the categories, or propositions may be specified that state predicted relationships (Creswell, 2007). The result of the qualitative coding process is a substantive level theory. As a result of the refugee determination process becoming an additional category, a 'story line' began to emerge, whereby theoretical connections were made between the categories. By identifying the existing barriers in the accessibility and delivery of mental health care to the refugee population, a paradox was discovered. The details of the paradox will be discussed in a later section.

4. Data Analysis

The themes that were uncovered in the grounded theory process will be thoroughly discussed in this chapter.

4.1 Characteristics of the Refugee Population

At the forefront, it is important to have a comprehensive understanding of the demographics of the current refugee population that the participants are interacting with. The participants were asked about the age, the gender and the country of origin of the refugee population. The aggregated results demonstrated that the participants classified the majority of the refugee population as "adults", ranging from middle life to late life, from the ages of thirty-sixty. They also stated that although they do see refugees who are under the age of eighteen and over the age of sixty, they were often accompanying other family members in the "adult" category. There was almost an absolute consensus among the participants that there was an equal amount of male and female refugees that they interacted with.

Lastly, the participants discussed the countries of origin, which were identified as being constantly in flux because of the "political decisions on who comes and who does not" (Physician, Male). The most consistent finding was that although the Hungarian Roma made up sixty percent of the patients at one time, this came to a stop at the end of 2012. In the first six months of 2013, it was reported that North Koreans were the largest population; however, this came to a stop at the end of 2013. The remaining findings were scattered but included the following countries of origin: Ukraine, Ethiopia, Somalia, Nigeria, Sudan, Sir Leon, Congo, Uganda, Bhutan, Nepal, Pakistan, Iran, Iraq, Afghanistan, Saudi Arabia, Sri Lanka, Caribbean, Columbia, and Mexico.

4.2 The Refugee Determination Process

During the initial stages of the research process, the refugee determination system was not a theme that was to be explored. However, as the stages of data collection and data analysis progressed the refugee determination system was identified as a significant component when exploring refugee mental health. The majority of the participants in their discussion identified a relationship between a diagnosis of post-traumatic stress disorder and the refugee determination system. More specifically, there was a consensus that labeling someone with a mental health diagnosis, particularly post-traumatic stress disorder, is useful for the refugee determination process. And, if there ceases to be a diagnosis of post-traumatic stress disorder the refugee claimant is less likely to be accepted in Canada, thus it becomes "a risk to say that someone has no DSM axis one diagnosis" (Psychiatrist, Female).

A large proportion of the participants revealed that as health care professionals their role is not only the provision of care, but "to write a very specific psychiatric report that has been requested by the lawyer to help with the refugee hearing process" (Psychiatrist, Female). "For the legal process, being able to use a term like post-traumatic stress disorder – it communicates something – it says that this person meets a certain criteria (Physician, Female). The Immigration and Refugee Board "want facts and a description […] they want to know does this person have post-traumatic stress disorder or do they not" (Physician, Female).

A participant explained that there is logic behind the relationship between post-traumatic stress disorder and credibility: there is a belief among the Immigration and Refugee Board that "if you are a refugee you have to be unfortunate, and so you would imagine that the more unfortunate you are, the more terrible your story is" (Physician, Male). Thus, the

diagnosis of post-traumatic stress disorder symbolizes that the refugee claimant has experienced trauma and has been affected by it. “If somebody has had all kinds of things happen and then somehow it does not match up in their psychiatric diagnosis or presentation then people start to have credibility problems with that person” (Psychiatrist, Female).

The participants also identified that the discourse surrounding asylum seekers in Canada has an impact on the refugee determination process. It is expressed that there has been “a change in the culture towards refugees […] that really paint[s] them in a way that portrays them as people cheating the system and taking advantage of the system” (Physician, Male). (Physician, Male). As a result, a diagnosis of post-traumatic stress disorder on the psychiatric report becomes “almost proof of [the refugee claimant’s] suffering” and dismisses the assumption that the asylum seeker is making a fraudulent claim (Psychiatrist, Female).

4.3 Systemic Barriers

The majority of the participants discussed the systemic barriers that exist for the refugee population in the accessibility and delivery of mental health care.

4.3.1 Navigation

The ability of the refugee population to navigate the mental health system was posited as a barrier. A participant painted a picture: imagine an individual gets off of an airplane – they have to find shelter and food, and a social worker, welfare worker and a lawyer – in addition to obtaining their hospital records (Psychiatrist, Female). In the attempt to obtain medical documents, it becomes difficult because they are “still trying to navigate the system, so they do not necessarily understand how the system works, and its incredibly complex, and often very

different from their country of origin" (Physician, Male). This is further exasperated by the "shortening of the amount of time people have to prepare their hearings, […] with the 60 day turn around it is extremely fast" (Psychiatrist, Female). It becomes nearly impossible for refugee claimants to obtain the most appropriate documentation for the hearing process.

4.3.2 Health Care Insurance

Furthermore, the participants discussed the amendments to the Interim Federal Health program as a systemic barrier for the refugee population. The largest challenge stems from the fact that although the majority of the refugee population does not understand the changes, most physicians do not understand them as well (Physician, Male). "The biggest challenge is the refugee system" (Physician, Female). This is because the service provider must have a comprehensive understanding of where the refugee is "in the system, in terms of health care coverage" (Physician, Female). Because "the cuts to refugee health care are incredibly complicated" there are negative consequences for the refugee population in accessing health care (Physician, Male). It was expressed that "there are good doctors who really want to provide care who have turned people away, just saying, 'we do not want to deal with this'" (Physician, Male). Because "some refugees do not have access to IFH funded programs" (Psychiatrist, Female), "every time it is always a challenge to figure out what we can get people care for" (Physician, Female).

In response to this, the participants were asked about the repercussions of the City of Toronto becoming a Sanctuary City. The majority of the participants applauded the idea behind this implementation; however, there was a concern that there are "so many different levels of complexity to it" (Physician, Female). Primarily, it was expressed that although Toronto is

recognized as a Sanctuary City, “it does not necessarily translate down to hospitals and clinicians and physicians” (Physicians, Male). And this is problematic, because in turn, “what we are asking for is for people to do work pro bono” (Physician, Male). Consequently, “for thousands of the refugees that are uninsured […] a system like this that works on volunteerism can only do so much” (Physician, Male).

4.4 Language Barriers

The participants thoroughly discussed the language barriers that exist for the refugee population in the accessibility and delivery of mental health care. Although there is a wealth of existing literature that explores language barriers, this research project provides additional information from the perspective of the service provider.

Because, “you are sitting at twenty to thirty per cent of people who do not understand any English at all” (Physician, Male), the relationship between the health care professional and the refugee is severely hindered. Consequently, it is often necessary for an interpretation service to be utilized. The participants who work at a federally funded institution explained that they have access to live interpreters or a telephone interpretation system. However, the participants who provided services in community-based health care centers expressed that they experience a great difficulty in accessing interpretation services because of the costs (Physician, Female). When it is not feasible for an interpretation service to be granted, the community-based centers operate “based off people bringing friends or family members”, a dynamic that is rendered “really improper” (Physician, Male). And, in other circumstances where there ceases to be an interpreter, a friend or a family member present, the health care professional is “trying to get a history using only a few words, which is absolutely inadequate” (Physician, Male).

It was cautioned that although the interpreter supplies a communication bridge between the health care professional and the refugee, this is not a flawless exercise. The most frequently noted challenge with the utilization of interpretation services is that vital information that is detrimental to an accurate mental health diagnosis disappears with the addition of a third member to the clinical relationship. The appropriately trained interpreters adopt a 'black box' model, whereby they "translate word for word what the person is saying" (Physician, Female). And this is problematic because "psychiatry is just so nuanced" and "the pieces that tend to get lost" may be the most vital in the mental health assessment (Physician, Female). Thus, "if someone was speaking English it would be easier to tell if their thought form was not organized in some way", due to their "fluency of speak" (Psychiatrist, Female). However, this becomes hindered when a language barrier exists.

4.5 Cultural Barriers

Throughout the interview process, all of the participants were passionate during the discussion of cultural barriers. There was a consensus among the participants that "cultural barriers are infinite" and that there lacks an awareness of the "extent [to which] we are constantly translating everything based on our own understanding of something" (Psychiatrist, Female). And this is important to this context, because there is "the mental health culture here and the culture of the individual refugee" (Psychiatrist, Female).

4.5.1 Systemic Level

At the systemic level, it was expressed that the majority of the refugee population has "no experience with the mental health system and in the countries that they are coming from

the mental health system may not be very developed" (Psychiatrist, Female). For example, one participant referenced Ethiopia, whereby "there is only one psychiatric hospital" and an individual only interacts with the mental health system if their "behaviour is somehow out of control" (Psychiatrist, Female). Consequently, when refugees arrive in North America "they have never seen a psychiatrist" and "may not really even understand what we do" or they identify the mental health system as "just one other hoop they have to jump through in order to work closer to getting their refugee status" (Psychiatrist, Female).

4.5.2 Interpersonal Level

At the interpersonal level, the symptoms that are associated with mental illness in the Western culture may not be deemed a medical complication in other cultures. For example, one participant discussed a situation whereby a refugee had a preoccupation with ghosts and with witches. And, "it was not clear how much of that was cultural and how much of that was specific to their illness" (Psychiatrist, Female). It was described that this "would not have been a barrier if that person would have been someone who grew up in Canada" (Psychiatrist, Female). As an extension of this, there is the emerging trend where "we tend to see the medicalization of distress", whereby there is a sole focus on "the individual medical problem" (Physician, Male). And there is a strong pushback from a number of refugee groups who plead that "these are social problems, we need to sort out the social problems rather than the psychological problems""(Physician, Male). Thus, it is cautioned that because culture is embedded within mental health, "being aware of that is really really important" (Physician, Female).

4.6 Diagnostic Statistical Manual

The majority of the participants question the appropriateness and accuracy of using the DSM as a screening tool with the refugee population. The first identified problem with the DSM is why there is a DSM (Physician, Male). The American Psychiatric Association introduced the DSM as a psychological screening tool because they "believed that American should not use the International Classification of Diseases" based on the merit that the World Health Organization should not "be able to define who is mad in America" (Physician, Male). The participant identified this as a fallacy by questioning why the American Psychiatric Association would think, "the DSM would be a good way of thinking through people's expression of illness" (Physician, Male). Accordingly, it is argued "the DSM is likely to be imprecise unless we believe that everyone around the world behaves the same or reacts the same, which would be a stupid thing to say" (Physician, Male).

In addition, the notion of who created the DSM was problematized. "The DSM is basically expert opinion, North American mental health professionals" have decided on Western norms "what is pathologized and what is not" (Physician, Male).

> *"There are problems with that even when you are talking about a culture that is not different from this culture. But I think that those problems are magnified or they are exasperated when you are talking about someone from a different culture because we are now potentially pathologizing someone's norm" (Physician, Male).*

The behaviours that come to be classified as a mental illness according to the DSM are relevant to the actor that has the most influence at a given time. Accordingly, "the

present has a lot to do with the [influence of the] pharmaceutical industry" (Physician, Female). As more behaviours are classified as mental disorders and are deemed worthy of medical interventions, the "pharmaceutical industry obviously benefits from […] suggesting that something is a clear diagnosis that then needs a clear treatment" (Physician, Female).

As a result of the combination of these aspects, it was expressed that "ninety-nine per cent of the time, the DSM is not appropriate" (Psychiatrist, Female). There was a consensus among the participants that "there was a time when we would add up criteria and if you did not add up to the total then you were fine"; however, it is not used "as a gospel in the same way" (Physician, Male). And, as the participants continue to interact with refugee populations who have experienced trauma they "discover that [they] have to approach it differently" (Psychiatrist, Female).

4.7 Post-Traumatic Stress Disorder

The participants discussed the positive and the negative aspects of a diagnosis of post-traumatic stress disorder.

A mental health diagnosis for the refugee population can be advantageous. A refugee may suffer from "nightmares, and tremendous anxiety, avoidant behaviour, dissociation, and hypervigiliency", and applying a label to these experiences "has been described as incredibly helpful" (Physician, Male). The symptoms that are attributed to the refugee experience become contextualized and normalized by a diagnosis of post-traumatic stress disorder (Physician, Male).

However, the majority of the participants raise concerns about applying a diagnosis of post-traumatic stress disorder on a refugee. The most frequently expressed notion was that: "people tend to get better over time" (Physician, Female). Despite the tremendous amount of trauma that the refugee population has been subjected to, "if you leave them long enough, once they get their feet on the ground, and the dust settles, most people do fine" (Physician, Male). And, because the health care professionals are completing the psychiatric assessment prior to the refugee hearing, they are "seeing somebody during the most stressful period of their lives" (Psychiatrist, Female). Consequently, a participant cautioned "over diagnosing people particularly at that phase in their migration trajectory" (Physician, Male).

In addition, the notion that "trauma equals post-traumatic stress disorder" is deemed problematic (Psychiatrist, Female). The refugee experience is often characterized by catastrophic events; however, because the refugee "might be experiencing reactions to an abnormal series of events – that does not make [the individual] a psychiatric patient" (Psychiatrist, Female). A participant rendered a question appropriate: "Is a diagnosis appropriate or is that just being a refugee? (Physician, Female).

The participants also addressed the impact of a diagnosis of post-traumatic stress disorder on a refugee, and this was highly linked to the notion of stigma. It was argued that "stigma tends to identify the individual as the problem, [that although] this happens to loads of different people, you are the person who has post-traumatic stress disorder" (Physician, Male). In turn, "there is some personal fall out with the idea that in some ways you have broken under the stress" (Physician, Male). Because a refugee must be a resilient individual to get to the country of asylum, it can be damaging to the individual if the message that they are given is

that they are mentally ill (Physician, Male). A participant revealed that although a diagnosis of post-traumatic stress disorder is documented on the psychiatric report, the label of the diagnosis is not communicated to the refugee, as this could colour their lens, and hinder their future steps in the integration process (Physician, Female).

Furthermore, a mental health diagnosis according to the merits of the Western psychiatric model is focused on the individual. "The conceptualization of the diagnosis as being an individual issue then leads to us ignoring the structures that we need in order to help people to succeed" (Physician, Male). A mental health diagnosis, especially post-traumatic stress disorder, does not take into account the trauma of migration, and the circumstances that are outside the scope of pre-migration trauma (Psychiatrist, Female). Alongside this notion, it ignores social supports and settlement services as a solution to the issue at hand. And, it questions the relevancy of the diagnosis if the refugee received assistance from the community (Psychiatrist, Female).

4.8 Treatment

The discussion regarding post-traumatic stress disorder and the subsequent treatment resulted in a consensus among the participants: "these guys do not need pills" (Psychiatrist, Female). Because of the biomedical model, it is often believed that pharmaceutical interventions are the most appropriate for those individuals who manifest certain reactions to trauma. However, "it depends on people's illness model – if you believe that your problems have been caused by social factors […] then there is a certain resistance to taking medication" (Physician, Male). The participants emphasized the importance of dealing with basic migration

needs, including “getting connected to community support, making sure people have food and housing and access to ESL programs” (Psychiatrist, Female).

A participant compared the refugee population with the white collar population who work on Bay Street in Toronto: “if you go to Bay Street you will see a whole bunch of people who are anxious and depressed, and none of them will go see a psychiatrist – they will go see a life coach” (Physician, Male). A life coach will direct them to “all of the things that you do to balance your life” and these “are the things that people put higher on the list then taking pills” (Physician, Male). Similarly for the refugee population, it becomes more important to learn how to “deal with things at an early stage of adjusting to a new life”, rather than being the subject of a pharmaceutical intervention (Physician, Female).

5. Conclusion and Discussion

The findings of this research project provide evidence that there is a paradox between the utilization of post-traumatic stress disorder as a measurement of credibility in the refugee determination system and the appropriateness of a diagnosis of post-traumatic stress disorder among the refugee population. This provides a unique perspective to the existing literature on the relationship between the refugee determination system and post-traumatic stress disorder. Below is a flowchart that outlines the paradox that was discovered:

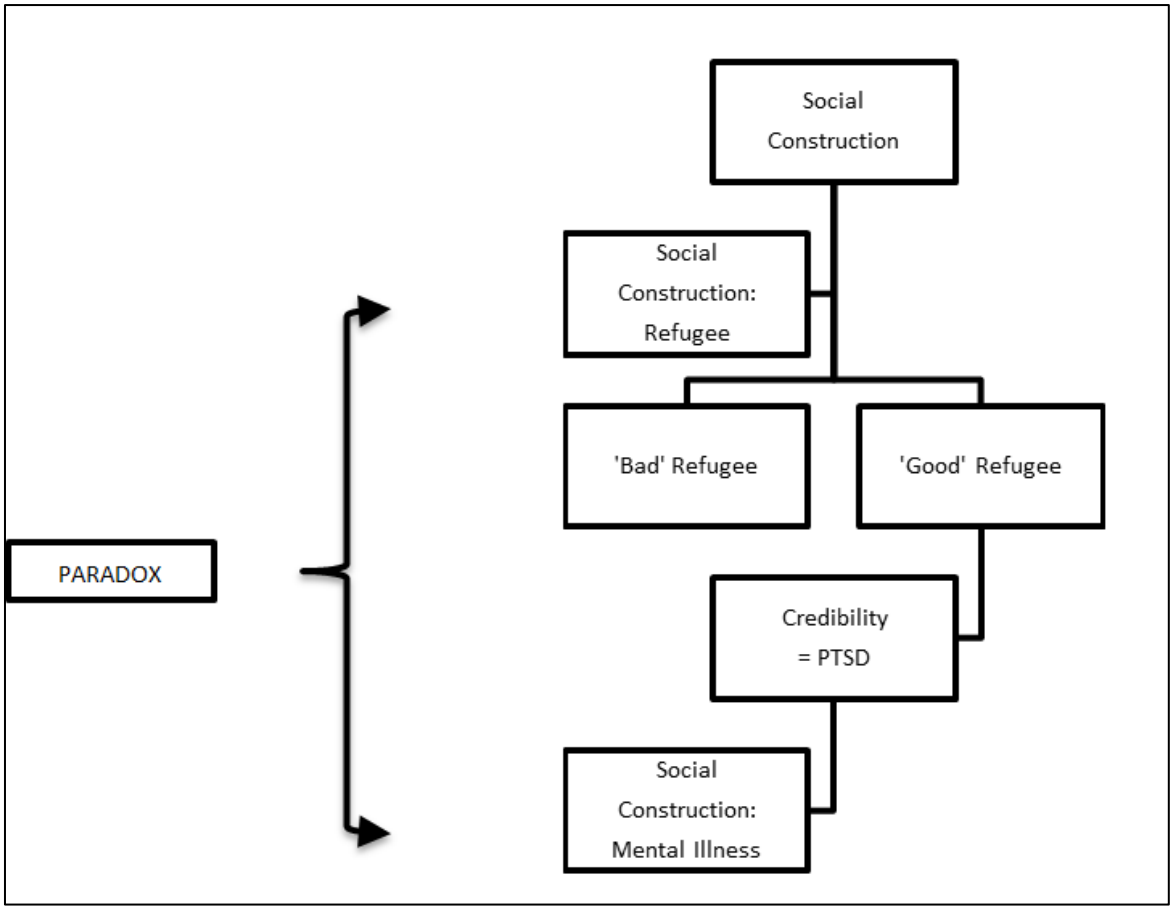

Figure 1: A paradox between the social construction of the refugee claimant and the social construction of mental illness and post-traumatic stress disorder

5.1 Refugee Determination System and Refugeeness

At the forefront of the discussion, is the relationship between the refugee determination system and the social construction of the refugee. It is apparent that the change in culture towards refugees, spearheaded by the Conservative government, is coupled with a 'bogus' discourse, rather than a humanitarian tone that once characterized the Canadian immigration and refugee system. It is particularly evident that this is surrounding the notion of 'asylum seekers' rather than the 'Convention refugee'. This dichotomy is referred to throughout the literature, whereby the 'good' refugee is one who remains in refugee camps until they are brought to Canada as government-assisted or privately sponsored refugees, and the 'bad' refugee is one who autonomously arrives in Canada seeking asylum of their own volition (Diop, 2014). Thus, it becomes the responsibility of the Immigration and Refugee Board to ensure that the 'bad' refugee does not threaten the sovereignty of the state. The Immigration and Refugee Board, according to the merits of this discourse are constantly seeking to prove that asylum seekers who arrive in Canada are fraudulent (Diop, 2014).

Correspondingly, it becomes the responsibility of the refugee claimant to supply evidence that will counter this discourse. In order to do this, as outlined in Figure 1, the refugee claimant subjectivity follows the concept of refugeeness, whereby the asylum seeker becomes an object defined by the law that is constructed according to the view of what a 'good' refugee is (Lacroix, 2000). The refugee claimant is required to act and look "like they are helpless, weak and vulnerable" in order to prove "their credibility as bonafide refugees" (Narula, 2003, p.10). "By obliging individuals to prove they are refugees, these exclusionary practices push them further into refugeeness" (Lacroix, 2000, p.185). The asylum seeker must fulfill the

characteristics, which by the merits of the Canadian refugee determination system, define who is a 'good' refugee.

5.2 Refugee Determination System and Post-Traumatic Stress Disorder

Although the practice of proving one's credibility during the refugee determination process has many dimensions, the focus of this research project was on the Basis of Claim document, and more specifically the psychiatric report. This is important because "it is often not possible to verify an account with reference to other forms of proof" besides the mandatory information in the Basis of Claim document (Luker, 2014, p.6). It is the psychiatric report that contains the evidence needed to fulfill the identity of refugeeness. This is where the relationship between the refugee determination system and post-traumatic stress disorder become important. This is because a diagnosis of post-traumatic stress disorder is particularly relevant to the refugee population, as it "becomes proof of [the refugee claimant's] suffering" (Psychiatrist, Female). As referenced in Figure 1, it symbolizes that the refugee claimant is a victim – that they have experienced trauma, and have manifested a certain set of reactions as a result. It dismisses the suspicion that this individual is a 'bogus' asylum seeker, and provides evidence that this refugee claimant is credible, as they fit within the category of the 'good' refugee according to the merits of the Canadian refugee determination system.

5.3 Post-Traumatic Stress Disorder and Social Construction

Although a diagnosis of post-traumatic stress disorder was identified as a necessary requirement to have on the psychiatric report, as outlined in Figure 1, it is posited that this is problematic because it appears that post-traumatic stress disorder is a social construction.

Because it is a social construction it was called into question whether post-traumatic stress disorder is an appropriate label to place upon refugee claimants who have experienced trauma. This question was addressed by referencing the barriers that exist in the accessibility and delivery of mental health care to those who originate from a non-Western culture. These barriers demonstrate that post-traumatic stress disorder may only be relevant to those whose lives are embedded within the Western culture.

Because a significant proportion of refugee claimants are not fluent in English, an interpreter is often required to facilitate the clinical discussion between the health care professional and the refugee. Although the interpreter alleviates the language barriers in determining if a refugee claimant's behaviours constitute a mental illness, the interpreter's presence also adds a layer of complexity to the interaction.

The interpreter may cease to transfer the nuances that are connected to the cultural meaning of the information being provided by the refugee. Subsequently, the health care professional may accept the information at face value and perceive it according to North American societal norms. This ultimately silences the 'patient's' pre-migration cultural background and meanings that their respective culture gives to symptoms that are connected to sorrow, loss and grief. Thus, language barriers are intimately connected to cultural barriers.

In particular, with a focus on post-traumatic stress disorder, the Western psychiatric model pathologizes distress; and the Western psychiatric model is entrenched within the DSM: North American mental health experts created it in order to define madness in America. The DSM dictates what is pathologized and what is not pathologized; or, what is 'normal' and what is 'abnormal' behaviour. However, the symptoms that refugee claimant's manifest may be

culturally relevant and culturally appropriate in accordance to their country of origin. The social norms as defined by the Western psychiatric model may differ significantly from the societal norms in a non-Western country. And this becomes problematic for refugee claimants, because in order to be classified as a refugee, one needs to have experienced some sort of trauma that has resulted in them fleeing a specific location. The Western psychiatric model assumes that the experience of trauma renders the diagnosis of post-traumatic disorder appropriate. However, for the refugee claimant their response to a traumatic event is a normal reaction and a normal adaptation to the refugee experience. According to their societal norms, they are not 'patient's'; rather, they are refugees.

5.4 Paradox

The findings of this research project demonstrate the existence of a paradox as outlined in Figure 1: the social construction of the refugee claimant and the social construction of post-traumatic stress disorder. The social construction of the refugee claimant deems that there is a distinction between the 'good' refugee and the 'bad 'refugee. This dichotomy demands that the refugee claimant who is fleeing their country of origin adopts a subjectivity of refugeeness. The 'good' refugee' is one who is able to manifest refugeeness in accordance with the discourse of the Immigration and Refugee Board. The ability of the refugee claimant to manifest refugeeness is parallel to the notion of credibility. And, in order to be classified as a 'good' refugee and be granted refugee status, post-traumatic stress disorder has emerged as a flagship of the proof of suffering and victimhood – symbolizing refugeeness. However, post-traumatic stress disorder is a social construction – whereby trauma is medicalized based upon the Western psychiatric model. Thus, this research project sought to add to the existing literature

by exploring the barriers of diagnosing an individual who originates in a non-Western culture with a Western social construct. And, it sought to demonstrate how these barriers make it difficult to accept a diagnosis of post-traumatic stress disorder as an appropriate measurement of credibility during the refugee determination process.

5.5 Limitations and Future Research

This research project has many limitations; given these limitations several future research directions become logical extensions of the study. First, the study was a qualitative research design, and did not include a quantitative component. It would be insightful to include a statistical analysis of the proportion of refugee claimants who gain refugee status with or without a diagnosis of post-traumatic stress disorder. In addition, although the research project successfully identifies the barriers that exist in the mental health system, it would be interesting to include a statistical analysis on the frequency that these barriers occur and the subsequent impact that the barriers have on a mental health diagnosis. Second, the sample size was relatively small – thus reducing the ability to generalize the findings. If the study were to be replicated it would be interesting to expand the number of participants, and the geographical boundaries of the study. The barriers in the mental health system may differ according to geographical location, particularly when comparing rural and urban spaces. Third, because the refugee determination process involves a multi-faceted dynamic, this research project is limited to the perspective of the health care professionals. A future research direction may incorporate the perspectives of other interest groups such as a lawyer or immigration consultant, the members of the Immigration and Refugee Board, and the refugee claimants. Fourth, the utilization of elite interviews as the research instrument presents difficulties. Because the

participants generally possess specialized information, it is common for them to have restricted availability. As such, not all of the health care professionals who agreed to participate in this research project could be interviewed face-to-face. However, the data collected from the telephone interviews was unable to be used in the core data analysis, in order to ensure that the standardization of the research instrument was not compromised.

5.6 Implications

This research project has implications for the Canadian refugee determination system and the Canadian settlement system.

5.6.1 The Canadian Refugee Determination System

The findings of this research project demonstrate the importance of recognizing that there is a discourse disseminated by the Conservative government that has altered the way in which Canada responds to asylum seekers. And it is this discourse that must be challenged before any significant operational changes can be made to the Canadian refugee system. The notion that asylum seekers are 'bogus' further perpetuates the rhetoric that the sovereignty of Canada is under threat and must be protected. The 'bogus' discourse, exasperated by concerns about uncontrolled migration, has encouraged host countries, such as Canada, to adopt more stringent refugee determination procedures.

The counter-narrative offered by refugee activists, such as The Canadian Association of Refugee Lawyers, is particularly relevant to the implications of this research project. In order to dispel the myths regarding asylum seekers the following facts must be publicized: refugee claimants are legally entitled to arrive in Canada without documentation, and this does not

classify them as 'illegal'; refugee camps are not the 'regular' channels of refugee claimants to seek protection; rejected refugee claims are not 'bogus'; and, refugee claimants do not pose a threat to the nation-state (Canadian Association of Refugee lawyers, 2014). A counter-narrative will assist in eliminating the pervasive suspicion regarding refugee claimants in the system of asylum adjudication. In turn, rather than the focus being solely on the ability of the refugee claimant to prove credibility in accordance with the 'bogus' discourse, the refugee determination system can operate according to the Conventions of which Canada is a signatory. These Conventions are built on the premise of providing a safe harbor to the world's most vulnerable.

5.6.2 The Settlement System in Canada

The findings of this research project also have implications for the settlement system in Canada. There was a repeated emphasis on the importance of settlement services and how vital the fulfillment of migration needs is to the successful integration of a refugee. The significance of the psychiatric assessment undermines the settlement needs of the refugee. This research project implies that the Federal government, specifically Citizenship and Immigration Canada, should offer services to newcomers in their first year of settlement in Canada (Physician, Male). This is based on the logic that the government is responsible for the Canadian Military, the Royal Canadian Mounted Police, and Aboriginal Peoples – and there are services offered to these populations. However, in order for Canada to provide settlement services, the Federal government needs to reallocate its funding – to all settlement sectors including language programs, affordable housing, labour market integration, and education. In doing so, the existing barriers in the mental health system can also be addressed. This is an

investment in the future of Canada and of the refugee. Rather than allocating Canada's resources to combating the 'fraudulent' asylum seeker, the energy dedicated to the improvement of the settlement system would be much more beneficial. However, as the 'bogus' discourse surrounding asylum seekers continues to be perpetuated by the Conservative government, and Canada continues to sway from its humanitarian tradition, our "nation's reputation as a beacon of hope for the persecuted will continue to decline" (Kennedy, 2009, p.xvii).

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